U.S. Department of Labor

Office of Administrative Law Judges
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In the Matter of	:	
	:	
FRED D. DEAN	:	
Claimant,	:	Date: Feb. 9, 2001
	:	
vs.	:	Case No. 2000-BLA-00057
	:	
	:	
CASTLE BROTHERS TRACK & ROLLER COMPANY, INC.	:	
Employer,	:	
	:	
and	:	
	:	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS	:	
Party-in-Interest.	:	

Stephen J. Kalista, Esq.
For the claimant

John C. Johnson, Esq.
For the Employer

BEFORE: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

Statement of the Case

This proceeding involves a first claim for benefits under the Black Lung Benefits Act, as amended, 30 U.S.C. 901 et seq. (hereinafter "the Act") and regulations promulgated thereunder.[1] The Act and regulations provide compensation and other benefits to coal miners who are totally disabled

[1] All applicable regulations which are cited are included in Title 20 of the Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. Director's Exhibits are indicated as "DX" and Transcript of the Hearing is indicated as "TR."

due to pneumoconiosis and their dependents. The Act and regulations define pneumoconiosis ("black lung disease" or "coal workers' pneumoconiosis") asa chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment, including any chronic restrictive or obstructive pulmonary disease or impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. Section 718.201.

The instant claim was filed by the Claimant, Fred D. Dean, on April 16, 1997 (DX 1). On November 13, 1997, the District Director made an initial determination awarding benefits (DX 42). Because so many putative employers were named as parties to the case, Castle Brothers Track & Roller Company, Inc. was not notified of the claim until December 23, 1997 (DX 28). The Employer controverted the initial award on January 23, 1998 (DX 37). The claim was referred to the Office of Administrative Law Judges on February 10, 1998 (DX 43-45). A hearing was held on July 9, 1998 before Judge Mollie Neal, and, pursuant to the discussion she had with the attorneys, the claim was remanded to the District Director on July 16, 1998 for resolution of the responsible operator issue (DX 87, 88). In a proposed Decision and Order Memorandum of Conference dated September 15, 1999, the District Director awarded benefits and determined that Castle Brothers was the properly designated responsible operator (DX 118). Castle Brothers requested a hearing on October 15, 1999, and did not contest its status as the responsible operator (DX 122). The case was referred to the Office of Administrative Law Judges on October 21, 1999 (DX 124).

A formal hearing was held in Abingdon, Virginia on March 8, 2000, at which all parties were afforded a full opportunity to present evidence and argument. Director's Exhibits one (1) through one hundred twenty-five (125) were received into evidence without objection (TR 19-20). Employer offered into evidence the January 4, 1999 deposition of Dr. Gregory Fino (TR 6). Counsel for employer had discovered that the deposition transcript had never been forwarded to the Director or the Claimant, and provided a copy to the Claimant at the hearing. Counsel argued that good cause was shown for his failure to provide the deposition within twenty days of the hearing because Claimant's counsel had cross-examined Dr. Fino at the deposition, thus obviating any prejudice to him (TR 7). Claimant's counsel objected based on timeliness and the fact that Dr. Fino's report is in the record (TR 8-9). Because the twenty-day rule has been violated and because the Employer had ample time to discover that the deposition transcript had not been provided to the Director or Claimant, it was excluded from evidence (TR 18). Because the Claimant miner was last employed in the state of Virginia, the law of the Fourth Circuit Court of the United States controls. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989) (*en banc*). Since Claimant filed this application for benefits after January 1, 1982, Part 718 applies. Since the claim was pending on the effective date, January 19, 2001, of the December 20, 2000, amendments to Parts 718 and 725, consideration of the claim is governed by the amendments in accordance with their terms.

ISSUES

1. How much coal mine employment has been established?
2. Whether the miner has coal workers' pneumoconiosis?

3. Whether the pneumoconiosis arose out of coal mine employment?
4. Whether the miner is totally disabled?
5. Whether Claimant has proved that he is totally disabled due to pneumoconiosis?

FINDINGS OF FACT, DISCUSSION, AND CONCLUSIONS OF LAW

Background

The miner, Fred Dean, was born on August 29, 1948 (DX 1). He has a tenth grade education and married Donna Marie Billington on January 23, 1971 (DX 1, 12). They have a dependent child, Amanda Lynn Dean, born May 29, 1980 (DX 1, 13). In his second deposition, taken April 23, 1998, The miner testified that his daughter Amanda was seventeen years old, a high school student, and dependent upon him (DX 78).

Claimant has been treated by Dr. Kiser, his family physician, for ten to fifteen years. Claimant sees him every two months, and it was Dr. Kiser who prescribed oxygen, which the claimant uses as needed (DX 78). Claimant saw Dr. Ladley once for heart trouble, and now takes a steroid, heart medications, and uses three inhalers. Dr. Paranthaman referred the Claimant to Dr. Rosser, who first told him he has silicosis. The miner sees Dr. Rosser every six months (DX 78). The miner testified that he began smoking at the age of 16 and now smokes more than one pack of cigarettes a day (DX 41, p. 28). However, for the last six or seven years prior to his November 1997 deposition, the Claimant smoked about two packs a day. At his second deposition, the Claimant testified that while he currently smokes one and one-half packs of cigarettes a day, when he began smoking thirty years ago, he smoked less than a pack a day. At one point he smoked up to three packs a day, but on three different occasions, he quit. Thus, he believes he was a heavy smoker for 15 to 20 years (DX 78).

Length of Coal Mine Employment

The miner alleges ten years of coal mine employment (DX 1). In his Employment History form, he listed the following coal mine employers, all of whom he worked for as an equipment operator: Josephine Coal Company, for whom he worked in 1978; Little S Coal Corp., for whom he worked in 1979; Barnette Contractors, for whom he worked from 1979 to 1985; Mouse Coal Co., Inc. and SE Drilling Co., for whom he worked in 1986; and Castle Brothers Track & Roller, for whom he worked from 1994 to 1995 (DX 2). The Social Security Itemized Statement of Earnings confirms three and one-quarter years of employment with Josephine Coal Company and Little S Coal Corporation from 1976 to 1979; six additional years of employment with G.W. Barnette Contractors from 1979 through 1985; one year of coal mine employment with Moose Coal Company Inc. in 1986; and two years of employment with Castle Brothers from 1994 through 1995 (DX 4). W-2 forms confirm this employment (DX 5). A questionnaire completed by Barnette Contractors, Inc. reveals that it employed the miner from December 4, 1979 through May 20, 1982 and again from

November 15, 1982 through September 27, 1985, for a total of five and one-quarter years (DX 7, 8). The claimant's exact employment dates with Castle Brothers were February 18, 1994 through May 5, 1995, for a total of one year and three months, according to a questionnaire completed by the Employer (DX 9).

At his November 3, 1997 deposition, the miner testified that his first mining job began in December 1976 with Josephine Coal Company, which later changed its name to Little S (DX 41). He worked there about three years and began working for Barnette Contractors in December 1979 as an equipment operator. He was employed by Barnette for about five years, and after he was laid off, he went to work for Moose Coal Company about three months later. His most recent coal mining job was with Castle Brothers, where he was a contractor worker, operating equipment. He worked at three job sites, mostly at reclamation sites and three to four months at a strip mine, drilling and hauling coal. He last worked in July 1995 because all the contractors were laid off. All of his coal mine employment was above ground.

The miner also worked as a fabricator for Pak-Mor for five years. He cut sheet metal, ran a punch, and cut channel iron. He worked in a big, open building and was exposed to some fumes, but the building was well ventilated. After his coal mine employment, the miner worked as a highway flagger for about two years, ending on February 28, 1997.

Based on this evidence, the miner is credited with three and one-quarter years of coal mine employment with Josephine Coal Company/Little S Coal Corp., five and one-quarter years with Barnette, one year with Moose Coal Company, and one and one-quarter years with Castle Brothers, for a total of 10 3/4 years of coal mine employment within the meaning of Section 402(d) of the Act and Section 725.202 of the regulations.

Responsible Operator

Castle Brothers Track & Roller company, Inc. is the responsible operator liable for payment of any benefits which may be found to be due.

Findings of Fact - Medical Evidence

Chest X-ray Evidence[2]

Exh. No.	Date of X-ray	Date of Report	Physician/ Qualifications	Diagnosis

[2] The following abbreviations are used in describing the qualifications of the physicians: B = B-Reader, R = Board-Certified Radiologist. Although the credentials of these physicians are not in the record, judicial notice of their qualifications is taken in accordance with www.ABMS.org and the 2000 NIOSH B-reader list. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990).

DX 55	5/13/96	5/13/96	Kiser	Evidence of pulmonary hypertension with severe emphysematous changes in lungs
DX 24	5/13/96	8/7/97	Navani/B, R	1/1; p/t; 6 zones
DX 41	5/13/96	12/18/97	Scott/B, R	Negative for pneumoconiosis; hilar and mediastinal adenopathy; bilateral mid-lung infiltrates/fibrosis; changes compatible with granulomatous disease, especially sarcoid
DX 41	5/13/96	12/20/97	Wheeler/B, R	Negative for pneumoconiosis; adenopathy or dilation of pulmonary arteries; ill defined interstitial fibrosis or infiltrates in lower lateral portion right upper lung extending to lateral pleural and focal fibrosis with tiny linear scars in lower lateral portion left upper lung; check for sarcoid and Tuberculosis
DX 65	5/13/96	4/10/98	Fino/B	0/0; sarcoidosis, idiopathic interstitial fibrosis, and neoplasm must be considered
DX 64	3/6/97	4/9/98	Scott/B, R	Bilateral hilar adenopathy; mid-lung infiltrates or fibrosis compatible with sarcoid or Tuberculosis; hyperinflation of lungs; deep breath versus emphysema
DX 64	3/6/97	4/10/98	Wheeler/B, R	Bilateral hilar adenopathy and subtle right inferior paratracheal adenopathy compatible with Tuberculosis and/or sarcoid with ill defined infiltrate or fibrosis; possible minimal emphysema; no evidence of silicosis or coal workers' pneumoconiosis
DX 64	3/17/97	4/9/98	Scott/B, R	Hilar adenopathy; bilateral mid-lung infiltrates or fibrosis compatible with sarcoid and/or Tuberculosis; hyperinflation of lungs compatible with emphysema
DX 64	3/17/97	4/10/98	Wheeler/B, R	Bilateral hilar adenopathy and subtle right inferior paratracheal adenopathy with ill defined infiltrate or fibrosis compatible with Tuberculosis unknown activity; sarcoid

				could be present but Tuberculosis explains all the lung and hilar findings; probable emphysema; no evidence of silicosis or CWP
DX 64	4/16/97	4/9/98	Scott/B, R	Bilateral hilar adenopathy; bilateral mid-lung infiltrates/fibrosis; changes compatible with sarcoid or Tuberculosis; linear nature of the infiltrates not compatible with silicosis/CWP
DX 64	4/16/97	4/10/98	Wheeler/B, R	Bilateral hilar adenopathy and subtle right inferior paratracheal adenopathy with ill defined infiltrate or fibrosis compatible with Tuberculosis unknown activity; sarcoid present but Tuberculosis explains all the lung and hilar findings; probable emphysema; no evidence of silicosis or coal workers' pneumoconiosis
DX 64	6/5/97	4/9/98	Scott/B, R	Bilateral hilar adenopathy, possibly decreased form prior exam; bilateral mid-lung infiltrates/fibrosis, decreased on left; probable Tuberculosis, unknown activity, cannot rule out sarcoid; negative for pneumoconiosis
DX 64	6/5/97	4/10/98	Wheeler/B, R	Bilateral hilar adenopathy probably decreasing since last exam; ill defined fibrosis compatible with Tuberculosis unknown activity, probably healed; probable minimal emphysema; no evidence of silicosis or coal workers' pneumoconiosis
DX 26	6/10/97	6/10/97	Paranthaman/B	2/1; q/p; 6 zones; category A large opacities
DX 23	6/10/97	7/4/97	Navani/B, R	2/1; q/t; 6 zones; alternative possibility of sarcoidosis should be considered
DX 22	6/10/97	7/16/97	Gaziano/B	2/2; u/t; 5 zones; category A large opacities
DX 41	6/10/97	12/17/97	Scott/B, R	Negative for pneumoconiosis; probable hilar and AP window adenopathy; bilateral

				mid-lung infiltrates/fibrosis; changes compatible with granulomatous disease, sarcoid, or Tuberculosis
DX 41	6/10/97	12/20/97	Wheeler/B, R	Negative for pneumoconiosis; minimal enlargement hilar compatible with adenopathy or dilatation pulmonary arteries and possible subtle right lower paratracheal adenopathy or slight dilatation SVC; ill defined infiltrate or fibrosis lower lateral portion right upper lung with slight elevation minor fissure and minimal fibrosis or infiltrate in left upper lung and left mid lung; probable emphysema with decreased lung markings in medial portion right upper lung above hilum; check for sarcoid
DX 65	6/10/97	4/10/98	Fino/B	0/0; sarcoidosis, idiopathic interstitial fibrosis, and neoplasm must be considered
DX 15	6/25/97	6/25/97	Cooper	Poorly defined rounded density in the mid portion of the left lung toward its periphery
DX 21	6/25/97	8/7/97	Navani/B,R	1/1; q/t; 6 zones; ill-defined density in left mid zone raises question of bronchogenic carcinoma
DX 41	6/25/97	12/17/97	Scott/B, R	Negative for pneumoconiosis; probable hilar, mediastinal adenopathy; bilateral mid-lung infiltrates/fibrosis; changes compatible with granulomatous disease, sarcoid would be a good possibility
DX 41	6/25/97	12/20/97	Wheeler/B, R	Negative for pneumoconiosis; minimal enlargement hilar compatible with adenopathy or dilatation pulmonary arteries and possible subtle right lower paratracheal adenopathy or slight dilatation SVC; ill defined infiltrate or fibrosis lower lateral portion right upper lung extending to pleura with slight elevation minor fissure and minimal fibrosis or infiltrate in left upper lung and left mid lung; probable

				emphysema with decreased lung markings in medial portion right upper lung above hilum and near upper portion left hilum; small discoid atelectasis or scar left lower lung near apex heart; check for sarcoid and Tuberculosis
DX 65	6/25/97	4/10/98	Fino/B	0/0; sarcoidosis, idiopathic interstitial fibrosis, and neoplasm must be considered
DX 64	9/29/97	4/9/98	Scott/B, R	Bilateral hilar adenopathy, especially inferior portion right hilum; bilateral midlung infiltrates and/or fibrosis; new focal infiltrate on left; change compatible with Tuberculosis or possibly sarcoid; negative for pneumoconiosis.
DX 64	9/29/97	4/10/98	Wheeler/B, R	Minimal bilateral hilar adenopathy and ill defined fibrosis or infiltrate in posterior inferior right upper lung more so than left upper lung; compatible with Tuberculosis; subtle 1.5 cm mass in lateral left mid lung compatible with inflammatory disease or tumor; possible emphysema; no evidence of silicosis or coal workers' pneumoconiosis
DX 73	3/30/98	3/30/98	R. Rosser/P	Extensive interstitial and somewhat nodular appearing markings predominately involving the mid and upper lung fields bilaterally
DX 66	3/30/98	4/15/98	Scott/B, R	Focal peripheral infiltrates mid-upper lung, right greater than left possible pneumonia, Tuberculosis, or fibrosis due to a prior infection; negative for pneumoconiosis
DX 66	3/30/98	4/15/98	Wheeler/B, R	No obvious pneumoconiosis; subtle enlargement of hilar compatible with adenopathy or dilatation pulmonary arteries; moderate ill-defined infiltrate or fibrosis in lower lateral portion of right upper lung

DX 71	3/30/98	4/27/98	Fino/B	Diffuse interstitial lung disease in all six lung zones but not consistent with pneumoconiosis
DX 82	3/30/98	6/18/98	Paranthaman/B	3/2; r/u; 6 zones; category B large opacities
DX 83	3/30/98	6/19/98	DePonte/B, R	2/3; t/t; 6 zones; category B large opacities
DX 82	5/6/98	6/18/98	Paranthaman/B	3/2; r/ u; 6 zones; category B large opacities
DX 83	5/6/98	6/19/98	DePonte/B, R	2/3; t/t; 6 zones; category B large opacities
DX 92	8/4/98	10/2/98	Fino/B	Negative
DX 110	8/4/98	11/16/98	DePonte/B, R	2/2; s/t; 6 zones; size B large opacities
DX 110	8/4/98	2/21/99	Navani/B, R	1/1; q/r; 6 zones; size A large opacities

A CT scan of the thorax was taken on June 25, 1997, and read by Dr. J.B. Cooper, who diagnosed abnormal densities in both lungs consistent with pneumoconiosis (DX 15). Dr. Shiv Navani also interpreted this CT scan (DX 25). He found the appearances to be consistent with category 1/1 coal workers' pneumoconiosis. On December 30, 1997, Dr. Scott interpreted the CT scan as compatible with granulomatous disease, possibly sarcoid (DX 41). He opined that the changes were of the wrong type and in the wrong distribution to be due to silicosis or coal workers' pneumoconiosis. Dr. Wheeler believed tuberculosis was a more likely diagnosis than sarcoid because of the posterior upper lobe disease. His reading of December 20, 1997 did not include pneumoconiosis (DX 41).

Another CT scan of the thorax was taken on August 4, 1998 and interpreted by Dr. Shiv Navani as consistent with complicated changes of coal workers' pneumoconiosis (DX 114). Dr. Kathleen A. DePonte, a board certified radiologist and B-reader, also interpreted the CT scan as showing pneumoconiosis with bilateral progressive massive fibrosis.

Pulmonary Function Studies

Exh. No.	Test Date	Doctor	Co-op/Undst/TR[3]	FEV1	FVC	MVV	Qual.[4]	Hgt.[5]
DX 14	6/10/97	Paranthaman	Good/Good/Yes	1.08	2.65	47	Yes	66.5
				1.41	3.56	65	Yes	

Found acceptable by Dr. J. Michos, who is board certified in internal medicine and pulmonary medicine, on July 2, 1997 (DX 18).

DX 92	8/4/98	Fino	Good/Good/Yes	1.17	3.08	–	Yes	66"
				1.33	3.57	–	Yes	

Arterial Blood Gas Studies

Exh. No.	Test Date	Doctor	Condition	PCO2	PO2	Alt.	Qualify
DX 55	5/12/96	Kiser	resting	34	83	0-2999	No
DX 17	6/10/97	Paranthaman	resting	39	52	0-2999	Yes

Found technically acceptable by Dr. J. Michos, who is board certified in internal medicine and pulmonary medicine, on July 2, 1997 (DX 18).

DX 76	4/8/98	Moore	resting	42.4	54.1	0-2999	Yes
DX 92	8/4/98	Fino	resting	38.4	69.0	0-2999	No

Medical Reports/Opinions

The record contains the office notes from Dr. Kenneth Kiser, the miner's family physician, from June 23, 1987 through March 9, 1998 (DX 79). The miner presented with chest wall pain and a productive cough on several occasions. Dr. Kiser noted tobacco abuse, specifically, a history of smoking one to two packs of cigarettes a day for thirty years, and recommended that the miner quit smoking. He performed many physical examinations and diagnosed acute bronchitis which resolved according to later visits, chronic obstructive lung disease, asthma, chronic bronchitis, tachycardia, dyspnea, possible sarcoidosis, obesity, and acute sinusitis. Dr. Kiser is board-certified in family practice and geriatrics.

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[3]Conforming reports of pulmonary function studies must record the miner's level of cooperation and understanding of the procedures, and include three tracings of the maneuvers performed.

[4]Values listed on the first line are those values obtained pre-bronchodilator. The second line of the values shown indicate post-bronchodilator studies.

[5]Because of the various heights noted by the examining physicians, the discrepancy has been resolved by taking the average of the heights recorded. *See Protopappas v. Director, OWCP*, 6 BLR 1-221 (1983). In this case, the average is 66.25 inches.

The record contains records of two hospital admissions at Lonesome Pine Hospital in Big Stone Gap, Virginia (DX 55). The first hospital admission was from May 16, 1989 until May 19, 1989, for chest pain, dizziness and weakness. Dr. M. B. Ford, who is board-certified in family practice, admitted the Claimant at the emergency room, and Dr. Kiser attended the Claimant during the admission. Both found no evidence of myocardial infarction and diagnosed chest pain, myocardial infarction ruled out, chest wall pain, and tobacco abuse. Both doctors noted that the Claimant had smoked two packs of cigarettes per day for 25 years. The second admission was from May 12, 1996 to May 13, 1996, for sudden chest pain and weakness. Dr. David Brown was the admitting physician, and Dr. Kiser attended the Claimant. The doctors both considered a smoking history of two packs of cigarettes per day, a medical history and the results of a chest x-ray, blood gas study, EKG, and physical examination. Drs. Brown and Kiser diagnosed pulmonary hypertension with severe emphysematous changes, probable chronic lung disease secondary to smoking, supra ventricular tachycardia controlled, rule out coronary artery disease, and tobacco abuse.

The record contains hospital records from Houston Valley Medical Center in Kingsport, Tennessee dated May 13-15, 1996 (DX 41). Dr. Herbert Ladley attended the Claimant upon referral and transfer by Dr. Kiser for evaluation of supra ventricular tachycardia and chest discomfort. Dr. Ladley considered 10 years of strip mine employment, a history of smoking two packs of cigarettes per day for past 30 years, and a medical history including probable COPD, hyperlipidemia and a previous hospitalization in 1989 for dizziness and weakness. Dr. Ladley considered the results of an exercise treadmill thallium study, a Doppler echocardiography, and a physical examination. He diagnosed supra ventricular tachycardia secondary to caffeine and tobacco exposure, early chronic obstructive pulmonary disease related to smoking, and hyperlipidemia. Dr. Ladley is board-certified in internal medicine, cardiovascular disease, and interventional cardiology.

Dr. J. Bryston Winegar examined the Claimant on October 5, 1989 (DX 55). He considered a smoking history of two packs of cigarettes per day, symptoms, a medical history, and a physical examination. Dr. Winegar noted a normal exam for pre-employment with Pak-Mor. Dr. Winegar is board-certified in family practice.

Dr. S. K. Paranthaman examined the Claimant on June 10, 1997 (DX 16). He considered ten years of coal mine employment, last as a drill operator, a medical history significant for pneumonia, wheezing, chronic bronchitis, and heart disease, and a history of smoking two packs of cigarettes a day for 30 years. The miner complained of a productive cough and wheezing for the past five years and a habit of sleeping on two pillows for twenty years. Dr. Paranthaman conducted a physical examination, an EKG, pulmonary function and arterial blood gas studies and an x-ray. Dr. Paranthaman diagnosed complicated coal workers' pneumoconiosis due to coal dust exposure; chronic obstructive pulmonary disease due primarily to cigarette smoking; and reactive airway disease. In his opinion, the miner is totally disabled from returning to his last job as a drill operator based on the pulmonary function and blood gas study values, as well as clinical evidence of emphysema and x-ray evidence of category A large opacities. Dr. Paranthaman is board-certified in internal medicine, pulmonary disease, critical care medicine, and geriatric medicine (DX 20).

A claims examiner from the Department of Labor, on July 25, 1997, asked Dr. Paranthaman whether the miner's total disability was caused by his 9.34 years of coal mine employment (DX 19). In his August 8, 1997 response, Dr. Paranthaman stated a susceptible individual can develop changes of pneumoconiosis after only 9.34 years of coal mine employment. He added that the airway obstruction is probably primarily related to cigarette smoking and secondarily to coal dust exposure. He opined that the reactive airway disease, documented by the post-bronchodilator study, is not related to coal dust exposure, stating:

> However, people with reactive airway disease will find it difficult to work in a dusty atmosphere, which will provoke bronchospasm due to non specific irritation. Since Mr. Fred Dean has evidence of pneumoconiosis radiologically and has presence of a large opacity which might represent complicated pneumoconiosis, I consider him totally disabled due to his lung problem caused by coal mine employment.

Dr. Robert A. Rosser examined the miner in a follow-up visit on March 30, 1998 (DX 73). He considered a history of currently smoking one and one-half packs of cigarettes a day, symptoms of chronic cough and shortness of breath, and the results of an x-ray and physical examination. Dr. Rosser suspected that the nodular densities seen on x-ray are related to occupational disease and possibly granulomatous changes. Dr. Rosser is board-certified in internal medicine and pulmonary disease.

On April 8, 1998, Dr. Ben V. Branscomb reviewed medical evidence (DX 65). He considered hospital records from May 13-15, 1996; a history of smoking two packs of cigarettes a day for thirty years, ten years of coal mine employment at strip mines, Dr. Paranthaman's report, the June 25, 1997 CT scan report, fourteen x-ray interpretations of the May 13, 1996, June 10, 1997, and June 25, 1997 x-rays, and the pulmonary function and blood gas studies administered by Dr. Paranthaman. Dr. Branscomb considered the miner's coal dust exposure "extraordinarily small" and felt that based on the majority of x-ray interpretations and other evidence, there was no indication of any occupational pulmonary disease. He also felt that he had insufficient medical data to opine reliably whether the miner has a disabling pulmonary disease. He added that, if the miner has a pulmonary impairment, it is caused by asthma or asthmatic bronchitis secondary to a severe smoking addiction. Dr. Branscomb is board-certified in internal medicine.

Dr. Branscomb was deposed on May 20, 1998, at which time he discussed his credentials, reiterated the results of his medical review, and discussed other evidence (DX 91). He explained that he is not board-certified in pulmonary disease because that specialty was not given board certification until many years after he had already been practicing in the field. His status as a B-reader ended in December 1997. In his opinion, the miner's ten years of coal mine employment provided a very low amount of exposure, but Dr. Branscomb recognized that it could be sufficient to produce pneumoconiosis in a susceptible person. Dr. Branscomb noted a smoking history of two packs of cigarettes a day for thirty years by age forty-eight. He reviewed the March 6, 1997 CT scan and found sarcoid or tuberculosis, but not pneumoconiosis. He explained that simple pneumoconiosis must exist before a finding of complicated pneumoconiosis can be made, and that because the miner

did not have the former he cannot have the latter. He reaffirmed his opinion that there is no impairment due to coal mine employment. Rather, Dr. Branscomb found impairment due to asthma or asthmatic bronchitis secondary to severe smoking addiction. This opinion, he testified, is bolstered by the miner's excellent response to bronchodilator therapy. Dr. Branscomb reviewed Dr. Kleinerman's report and noted that it did not change his opinion. Finally, Dr. Branscomb explained that the finding of anthracotic pigment in the bronchoscopy biopsy sample tells him nothing because the sample of tissue is too small. However, he added that it does not exclude the possibility of pneumoconiosis.

Dr. Branscomb reviewed additional evidence on June 8, 1998 (DX 85). These included hospital records, the reports of Drs. Wheeler, Scott, Rosser, Kleinerman, Castle, and Fino, twenty-two x-ray readings, a pulmonary function study, and a blood gas study. He felt the additional data confirmed his opinion that the miner has a moderate to severe obstructive pulmonary disease–chronic asthmatic bronchitis due to smoking. He explained that the results of the ventilatory and blood gas studies confirmed this, and added that if the claimant received no treatment for his pulmonary function defect, he would be disabled for coal mine employment. However, with treatment, the miner would have the pulmonary capacity to perform his last coal mining job. Dr. Branscomb reaffirmed his opinion that the claimant has no impairment caused by or aggravated by coal dust exposure. Dr. Branscomb declared that a June 29, 1998 review of Dr. Kiser's records from June 1987 through March 1998 further confirmed and strengthened his opinions (DX 86).

Dr. William W. Scott, Jr. was deposed on April 29, 1998 (DX 78). He is a board-certified radiologist and B-reader. He reviewed his interpretations of x-rays taken May 13, 1996, March 6, 1997, March 17, 1997, April 16, 1997, June 5, 1997, June 10, 1997, June 25, 1997, and September 29, 1997, and CT scans of the thorax dated June 25, 1997 and March 6, 1997. Because he never found small, rounded opacities in the mid and upper lung zones, concentrated more centrally than peripherally, he never diagnosed coal workers' pneumoconiosis. Rather, he found adenopathy and either sarcoidosis or tuberculosis. He also ruled out complicated pneumoconiosis.

Dr. Jerome Kleinerman reviewed medical evidence on May 6, 1998 (DX 74). He considered nine and one-half years of coal mine employment in the strip mining industry as an equipment operator, a history of smoking two to three packs of cigarettes a day for thirty years, a medical history, hospital records, twelve reports of three separate x-rays, the June 10, 1997 pulmonary function study, the June 10, 1997 blood gas study, and CT scan results. Dr. Kleinerman also viewed four histologic slides from the miner's April 16, 1997 bronchoscopy. He did not diagnose either simple or complicated pneumoconiosis. He ascribed the miner's pulmonary function changes–moderate to marked obstructive and moderate restrictive lung dysfunction with a moderate degree of arterial hypoxemia-- to his smoking history.

Dr. Kleinerman was deposed on May 26, 1998 (DX 77). He disclosed his credentials as being board-certified in anatomic and clinical pathology with a special interest in diseases of the lungs. He explained that, in order to diagnose coal workers' pneumoconiosis, three criteria are necessary: the existence of a macule; the macule must be located in a respiratory bronchiole; and focal

emphysema must be present in the vicinity of the macule. Dr. Kleinerman reviewed medical records and lung biopsy material from an April 16, 1997 bronchoscopy on May 6, 1998. He also considered a blood gas study, EKG, and pulmonary function studies administered by Dr. Castle on May 6, 1998. He found benign squamous metaplasia and changes characteristic of chronic bronchitis. He could not make the diagnosis of pneumoconiosis because the biopsy sample did not include lung alveolar tissue. He explained that a finding of black pigment is not diagnostic of pneumoconiosis because it could be due to many conditions endemic to urban living. Based on a sixty- to ninety-pack-year smoking history, Dr Kleinerman did not find the diagnosis of squamous metaplasia and chronic bronchitis unusual. He added that the pulmonary function and blood gas studies bolstered his findings of severe obstructive airways disease due to smoking and hypoxemia with decreased diffusing capacity due to smoking, respectively. Based on the x-rays he reviewed, Dr. Kleinerman opined that the miner does not have pneumoconiosis or any lung impairment arising out of coal mine employment.

On May 28, 1998, Dr. James R. Castle examined the Claimant and reviewed medical records (DX 80). He considered symptoms of shortness of breath, a cough, and wheezing, a medical history, a history of smoking one and one-half packs of cigarettes a day, having begun at age seventeen, and ten years of coal mine employment as a heavy equipment operator. Dr. Castle also administered a chest x-ray, a pulmonary function study, and a blood gas study, and performed a physical examination. He found no evidence of coal workers' pneumoconiosis, either simple or complicated. He diagnosed tobacco-smoke-induced chronic obstructive pulmonary disease with asthmatic bronchitis and pulmonary emphysema which he believes caused severe obstructive airway disease and mild hypoxemia. Dr. Castle opined that the x-rays revealed hilar adenopathy and infiltrates consistent with sarcoidosis and/or healed tuberculosis.

Dr. Castle also reviewed twenty-nine x-ray interpretations and CT scan interpretations, the June 10, 1997 blood gas study and pulmonary function study, hospital records, and the reports of Drs. Wheeler, Scott, Paranthaman, Rosser, Branscomb, Fino, and Kleinerman. This information did not cause him to change his opinion. He explained that, because none of the physicians found rales, crackles, or crepitations on physical examination, and because of the miner's smoking history compared with a coal mine employment history of only ten years, the improvement after bronchodilator administration that is typical of smoking-induced defects like chronic obstructive pulmonary disease, the improvement of the PO2 over time, and the pathology report, a finding of pneumoconiosis is not indicated. Dr. Castle opined that the miner has chronic obstructive pulmonary disease with asthmatic bronchitis and emphysema. He opined that the Claimant is totally disabled due to tobacco-smoke-induced chronic obstructive pulmonary disease, including bronchitis and emphysema, but not coal mine employment. Dr. Castle further opined that even if the miner were found to have pneumoconiosis, his opinion regarding disability and the cause thereof would remain unchanged.

Dr. Gregory J. Fino examined the miner on August 4, 1998 (DX 92). He considered a history of smoking two packs of cigarettes a day since 1964, ten years of above ground coal mine employment, ending in 1995, symptoms of shortness of breath, wheezing, and a daily productive

cough, and the results of an x-ray, pulmonary function study, blood gas study, and physical examination. He diagnosed interstitial lung disease of indeterminate etiology and cigarette smokers' emphysema.

Conclusions of Law and Discussion

To be entitled to benefits under Part 718, Claimant must establish by a preponderance of the evidence that (1) he suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) he is totally disabled; and (4) his total disability is caused by pneumoconiosis. *See Gee v. M.G. Moore & Sons*, 9 BLR 1-4 (1986). Failure to establish any of these elements precludes recovery under the Act.

Existence of Pneumoconiosis

Section 718.202(a) provides four bases for finding the existence of pneumoconiosis: (1) a properly conducted and reported chest x-ray; (2) a properly conducted and reported biopsy or autopsy; (3) reliance upon certain presumptions which are set forth in Sections 718.304, 718,305, and 718.306; or (4) the findings by a physician of pneumoconiosis as defined in Section 718.201 which is based upon objective evidence and a reasoned medical opinion.

There are thirty-seven x-ray readings in evidence based on eleven x-rays. Of the thirty-seven readings, nine are by either board-certified radiologists or B-readers, and twenty-five are by board-certified radiologists who are also B-readers. Eleven readings were positive for pneumoconiosis, while twenty-six were negative.

The first x-ray, dated May 13, 1996, was interpreted as revealing emphysema by Dr. Kiser, who possesses no particular qualifications for x-ray interpretation. Dr. Navani, who is both a B-reader and board-certified radiologist, interpreted the x-ray as category 1/1 pneumoconiosis. However, Drs. Scott and Wheeler, both of whom are dually certified, interpreted the film as negative, as did Dr. Fino, a B-reader. Based on the preponderance of this evidence, this x-ray is negative for pneumoconiosis.

The March 6, 1997, March 17, 1997, April 16, 1997, and June 5, 1997 x-rays were read as negative by Dr. Wheeler and Dr. Scott. Consequently, these four x-rays are deemed negative for pneumoconiosis.

The June 10, 1997 x-ray was interpreted as positive by Drs. Paranthaman, Navani, and Gaziano, while Drs. Scott, Wheeler, and Fino reread the film as negative. Dr. Paranthaman, a B-reader, interpreted the x-ray as disclosing category two pneumoconiosis and category A large opacities, indicating complicated pneumoconiosis. Dr. Gaziano, a B-reader, also interpreted the x-ray as disclosing category two pneumoconiosis with category A large opacities. Dr. Navani, a dually-qualified reader, interpreted the x-ray as disclosing category one pneumoconiosis, but not

complicated pneumoconiosis. He also recorded that sarcoidosis had to be considered as a diagnosis. Drs. Scott and Wheeler, who are dually-qualified readers, identified sarcoidosis as a probable diagnosis, but did not find pneumoconiosis. Dr. Fino, a B-reader, did not find pneumoconiosis. While the readings on this film are almost equally divided, the x-ray is determined to be negative, if viewed in isolation, and considering the slight edge in professional credentials, and so, based on a preponderance of the related evidence. Also, since the existence of complicated pneumoconiosis is not deemed to have been established on the record as a whole, the interpretations of Drs. Paranthaman and Gaziano are appropriately given less weight.

The June 25, 1997 x-ray was initially read by Dr. Cooper, who identified a poorly defined density, but did not identify pneumoconiosis. Dr. Navani found category 1/1 pneumoconiosis, while Drs. Scott, Wheeler, and Fino did not. Dr. Navani's finding of category 1/1 pneumoconiosis, however, is inconsistent with his finding of category 1/2 on the June 10, 1997 film. Since pneumoconiosis is a progressive and incurable disease, this factor calls into question the accuracy of Dr. Navani's conclusion. Moreover, because three other qualified readers found this x-ray negative, it is deemed to be negative for pneumoconiosis.

The September 29, 1997 x-ray was read as negative for pneumoconiosis by Drs. Scott and Wheeler, and was not reread. The March 30, 1998 x-ray was read as negative by Dr. Rosser, who lacks relevant qualifications, and Drs. Scott, Wheeler, and Fino confirmed that interpretation. Dr. Paranthaman diagnosed category 3/2 pneumoconiosis with size B large opacities, and Dr. DePonte, a B-reader and board-certified radiologist, found category 2/3 pneumoconiosis and size B large opacities. Thus, while three physicians found the x-ray negative for pneumoconiosis, two others diagnosed complicated pneumoconiosis. Of the three best qualified readers, two found the film negative and one found it positive. The two B-readers are split as to the presence or absence of pneumoconiosis on this x-ray. Consequently, based on a preponderance of the evidence, this film is deemed to be negative.

The May 6, 1998 x-ray was found positive by both Drs. Paranthaman and DePonte, and was not reread. They again found category 3/2 and 2/3, respectively, and size B large opacities. Therefore, this x-ray is deemed positive for pneumoconiosis.

The most recent x-ray, taken August 4, 1998, was found negative by Dr. Fino, a B-reader, but both Dr. DePonte and Dr. Navani found the x-ray positive. Dr. DePonte found category 2/2 pneumoconiosis with size B large opacities, and Dr. Navani found category 1/1 pneumoconiosis with size A large opacities. Because Dr. DePonte and Dr. Navani are dually-qualified, their interpretations support a finding that this x-ray is positive for pneumoconiosis.

The overall weight of the x-ray evidence, however, does not support a finding of pneumoconiosis. The majority of the best-qualified readers found the x-rays negative for the disease despite the consistent findings of lung abnormalities. Specifically, five B-readers found the x-rays negative and four found them positive. Eighteen of the B-readers who are also board-certified radiologists found the x-rays negative, while only seven found them positive. *See Scheckler v.*

Clinchfield Coal Co., 7 BLR 1-309 (1984). While the two most recent x-rays are positive, they are the most recent only by a few months. The majority opinion of the best qualified readers is more persuasive. Consequently, this tribunal concludes that the x-ray evidence does not establish the existence of pneumoconiosis under Section 718.202(a)(1).

The miner underwent a bronchoscopy on May 6, 1998, at which time some of his lung tissue was removed. According to Dr. Kleinerman, a reviewing pathologist, the tissue revealed benign squamous metaplasia and changes characteristic of chronic bronchitis. Because there was no lung alveolar tissue in the sample, he could not make a diagnosis of pneumoconiosis. Similarly, Dr. Branscomb testified that the sample was too small to indicate whether pneumoconiosis was present. Both of these physicians are board-certified specialists, and theirs is the only testimony on the biopsy evidence. Consequently, the biopsy evidence does not establish the existence of pneumoconiosis under Section 718.202(a)(2).

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if any of the presumptions described in Sections 718.304, 718.305, or 718.306 are applicable. Section 718.305 is not applicable because the miner's claim was filed after January 1, 1982. Section 718.306 is not relevant because that section requires that the miner must have died before 1978. Section 718.304 is applicable to the extent discussed below.

Pursuant to Section 718.202(a)(4), Dr. Paranthaman diagnosed pneumoconiosis, and Dr. Rosser suspected that the nodular densities he saw on x-ray were related to occupational disease. This is sufficient to be considered a diagnosis of pneumoconiosis. Drs. Kiser, Brown, Ladley, Branscomb, Kleinerman, Castle, and Fino did not diagnose the disease. Dr. Scott did not find pneumoconiosis, but his opinion does not rise to the level of a reasoned medical opinion under Section 718.202(a)(4) because he did not consider the miner's smoking and coal mine employment histories. Nor did he either examine the Claimant or review reports of other physicians' examinations of the Claimant. *See Perry v. Director, OWCP*, 9 BLR 1-1 (1986). Dr. Winegar provided no opinion on the existence of pneumoconiosis.

Substantial weight is placed on Dr. Kiser's opinion because he has been the miner's treating physician for ten to fifteen years, and he has been seeing the Claimant every two months (DX 78). He has treated the miner for his respiratory condition and has prescribed oxygen. He attended the miner during his hospital stays. Not only has he physically examined the miner many times, but has also considered the results of an x-ray, a blood gas study, and an EKG, as well as accurate smoking and employment histories. Consequently, Dr. Kiser has observed the miner long enough and frequently enough to have obtained a superior understanding of his condition and relevant information concerning his condition. *See Tussey v. Island Creek Coal Co.*, 982 F.2d 1036, 1042 (6th Cir. 1993); *Schaaf v. Matthews*, 574 F.2d 157, 160 (3d Cir. 1978); *Gomola v. Manor Mining and Contracting Corp.*, 2 BLR 1-130, 1-135 (1979); Section 718.104(d)(1)-(4). Dr. Brown's opinion, which included a diagnosis of pulmonary disease not related to coal mine employment, is persuasive because it is well reasoned and documented. *See Perry*, 9 BLR 1-1. The x-ray he relied on was read as negative for pneumoconiosis by Drs. Scott, Wheeler, and Fino.

Because Dr. Ladley did not examine the miner for the purpose of discovering a respiratory or pulmonary problem, but rather focused on the miner's cardiac condition, his failure to diagnose pneumoconiosis is not deemed significant.

Dr. Paranthaman's opinion is well documented and reasoned. *Perry*, 9 BLR 1-1. The first x-ray on which he relied was confirmed by two other qualified readers, although three others read it as negative. The second x-ray he considered was also confirmed by two B-readers who are also board-certified radiologists. Dr. Paranthaman also has significant credentials in pulmonary medicine. *See Scott v. Mason Coal Co.*, 14 BLR 1-38 (1990). The CT scan he considered was found to be consistent with pneumoconiosis by Dr. Cooper, who is neither a board-certified radiologist nor a B-reader. However, Drs. Scott and Wheeler, both of whom are dually certified, interpreted the CT scan as not revealing pneumoconiosis. Therefore, while there are some factors detracting from the probative value of Dr. Paranthaman's opinion, it nevertheless is given some weight. Dr. Rosser's opinion is less persuasive. Although he has treated the miner every six months, the record evidences only his March 30, 1998 examination. At that time, he did not consider a coal mine employment history or the length of time the miner had been smoking, and so his opinion is inadequately documented. *See Minton v. Director,* OWCP, 6 BLR 1-670 (1983); *Perry*, 9 BLR 1-1.

Dr. Branscomb's opinion merits greater weight because he reviewed specified medical evidence of record, he is a specialist in pulmonary disease, though not board-certified, and his opinion is supported by the overall weight of the x-ray evidence and the biopsy evidence. Dr. Kleinerman's opinion is persuasive because of his credentials. *See Wetzel v. Director, OWCP*, 8 BLR 1-139 (1985). Furthermore, his report is well reasoned in that it explains how his opinion is supported by the analysis of the biopsy tissue, the pulmonary function study results, and the miner's smoking and employment histories. Similarly, Dr. Castle explained that his conclusion was bolstered by the results of his and others' physical examinations, the miner's smoking and coal mine employment histories, the improvement of the miner's condition after bronchodilator administration, the improvement of his PO2 over time, and the pathology report. Dr. Castle also has significant credentials, and he examined the miner as well as reviewed specified medical records. For these reasons, his opinion is given substantial weight. Dr. Fino is board-certified in pulmonary medicine, and his report is well documented. However, his x-ray interpretation was reread as positive for complicated pneumoconiosis by two B-readers who are also board-certified radiologists. A CT scan taken the same day was also interpreted as positive for pneumoconiosis by these two physicians, whose radiological qualifications exceed those of Dr. Fino's. For these reasons, Dr. Fino's opinion is given some weight, but it is not as persuasive as the opinions of Drs. Kiser, Branscomb, Kleinerman, and Castle. Accordingly, the medical opinion evidence does not support a finding of the existence of pneumoconiosis under Section 718.202(a)(4).

Additional medical evidence of record includes the CT scans taken June 25, 1997 and August 4, 1998. The former was interpreted as positive for pneumoconiosis by Dr. Cooper, who is not a board-certified radiologist, and Dr. Navani, who is. That CT scan was interpreted as negative for pneumoconiosis by two other board-certified radiologists. Therefore, the weight of the evidence regarding this CT scan is negative for pneumoconiosis. The later August 4, 1998, CT scan was

interpreted as positive for complicated pneumoconiosis by two board-certified radiologists. Although that CT scan is more recent than the June 25, 1997, CT scan by more than one year, the earlier interpretations and explanations of Drs. Scott and Wheeler are more persuasive. Dr. Scott explained that the changes seen were of the wrong type and in the wrong distribution to be pneumoconiosis. Both he and Dr. Wheeler suspected sarcoidosis. Therefore, upon consideration of all the medical evidence bearing on the existence of pneumoconiosis, including the x-ray evidence, the evidence related to the two CT scans, and the opinions of physicians, this tribunal finds that the Claimant has failed to establish the existence of pneumoconiosis pursuant to Section 718.202. *See Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000); *Penn Allegheny Coal Coo. V. Williams*, 114 F.2d 22, 24-25 (3d Cir. 1997).

Causation

In addition to establishing the existence of pneumoconiosis, a claimant must also establish that his pneumoconiosis arose, at least in part, out of his coal mine employment. Pursuant to Section 718.203(b), a claimant is entitled to a rebuttable presumption of a causal relationship between his pneumoconiosis and his coal mine employment if he worked for at least ten years as a coal miner. In the instant case, Claimant established ten and three quarters years as a coal miner. Thus, had he established the existence of pneumoconiosis, he would have also been entitled to the rebuttable presumption that his pneumoconiosis arose from his coal mine employment under the provisions of Section 718.203(b). But, because he has not established the existence of pneumoconiosis, the issue is moot.

Disability Due to Pneumoconiosis

Section 718.304 provides an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if he is suffering from a chronic dust disease of the lung which, when diagnosed by chest x-ray, yields one or more large opacities classified in Category A, B, or C, or when diagnosed by biopsy or autopsy, yields massive lesions in the lung.

The first finding of complicated pneumoconiosis was of the June 10, 1997 x-ray. Drs. Paranthaman and Gaziano found category A large opacities. However, Drs. Navani, Scott, Wheeler, and Fino found this film negative for pneumoconiosis. Drs. Navani, Scott, and Fino suspected sarcoidosis. Based on the readings by the three dually-certified readers–Drs. Navani, Scott, and Wheeler–this x-ray is determined to be negative for complicated pneumoconiosis

The March 30, 1998 x-ray was interpreted by Drs. Paranthaman and DePonte as revealing category B large opacities. Drs. Fino, Rosser, Scott, and Wheeler did not find indicia of complicated pneumoconiosis to be present. Drs. Paranthaman and Fino are B-readers, Drs. Fino and Rosser are board-certified in pulmonary disease, which is not a qualification recognized for x-ray readers under the Act, but Drs. DePonte, Scott and Wheeler are both B-readers and board-certified radiologists. Consequently, the interpretations of Drs. DePonte, Scott, and Wheeler are most persuasive. See *Scheckler*, 7 BLR 1-128. Dr. Scott suspected pneumonia, tuberculosis, or fibrosis due to a prior infection. Dr. Wheeler found adenopathy. Thus, the preponderance of the evidence weighs against

an interpretation of complicated pneumoconiosis.

The May 6, 1998 x-ray was interpreted as exhibiting category B large opacities by Drs. Paranthaman and DePonte. Because this evidence is not contradicted, it is deemed to be positive for complicated pneumoconiosis. Likewise, the August 4, 1998 x-ray was interpreted as negative for pneumoconiosis by Dr. Fino, but Dr. DePonte found category B large opacities and Dr. Navani found category A large opacities. As Drs. DePonte and Navani are both board-certified radiologists, deference to their opinions is appropriate, as, together, those opinions constitute a preponderance of the evidence relative to that x-ray. Therefore, the x-ray is deemed to be positive for complicated pneumoconiosis.

Of the two CT scans which were also taken, the June 25, 1997 CT scan was not interpreted as revealing complicated pneumoconiosis. However, the August 4, 1998 CT scan was interpreted by Dr. Navani as consistent with complicated changes of pneumoconiosis, consistent with his interpretation of the x-ray taken the same day. Dr. DePonte found bilateral progressive massive fibrosis, a form of complicated pneumoconiosis, which is consistent with her reading of the August 4, 1998 x-ray.

Further bearing on the presence or absence of complicated pneumoconiosis are the opinions of Drs. Paranthaman, Branscomb, Scott, Kleinerman, and Castle. Dr. Paranthaman diagnosed complicated pneumoconiosis in his report based on his June 10, 1997 examination of the Claimant. He explained, "Mr. Fred Dean has evidence of pneumoconiosis radiologically and has presence of a large opacity which might represent complicated pneumoconiosis." This further explanation evinces some question in the doctor's mind regarding the presence of complicated pneumoconiosis. Such a finding that is not definitive is given less weight. *See Justice v. Island Creek Coal Co.*, 11 BLR 1-91 (1988). Drs. Branscomb, Scott, Kleinerman, and Castle agree that the miner does not suffer from complicated pneumoconiosis. As explained by Dr. Branscomb, if a person does not have simple pneumoconiosis, he cannot have complicated pneumoconiosis, since the former must exist before the latter can. The weight of the evidence is against a finding of simple coal workers' pneumoconiosis. Dr. Scott reviewed eight of the x-rays and both CT scans. He found adenopathy and either sarcoidosis or tuberculosis, but explained that the pattern of the opacities was not consistent with either simple or complicated pneumoconiosis.

The opinions of Dr. Scott and Dr. Branscomb, as supported by those of Drs. Kleinerman and Castle are well reasoned and substantiated by the underlying objective evidence. Those opinions are bolstered by the miner's smoking history and relatively short coal mine dust exposure, all of which was above ground. Thus, despite the interpretations of the two most recent x-rays and the more recent CT scan, this tribunal, having weighed all of the relevant evidence together, finds that the Claimant is not entitled to invoke the irrebuttable presumption that he is totally disabled due to pneumoconiosis pursuant to Section 718.304.

Section 718.204(b)(2) provides the criteria for determining whether a miner is totally disabled. These criteria are: (1) pulmonary function tests qualifying under applicable regulatory

standards; (2) arterial blood gas studies qualifying under applicable regulatory standards; (3) proof of pneumoconiosis and cor pulmonale with right sided congestive heart failure; or (4) proof of disabling respiratory or pulmonary condition on the basis of the reasoned medical opinions of a physician relying upon medically acceptable clinical and laboratory diagnostic techniques. If there is contrary evidence in the record, all the evidence must be weighed in determining whether there is proof by a preponderance of the evidence that the miner is totally disabled by pneumoconiosis. *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-95 (1986).

Since both the pre-bronchodilator and post-bronchodilator results of both pulmonary function studies produced qualifying values that exceed those set forth in Appendix B to Part 718, the Claimant has established that he is totally disabled pursuant to Section 718.204(b)(2)(i).

Of the four blood gas studies, two yielded qualifying values under Appendix C to Part 718 and two did not. Because the most recent study showed improvement just four months after a qualifying study, deference is given to Dr. Castle's opinion that the improvement in PO2 over time detracts from a finding of total disability. Therefore, the Claimant has not established total disability, by a preponderance of the evidence, pursuant to Section 718.204(b)(2)(ii). Since there is no evidence of cor pulmonale with right-sided congestive heart failure, the Claimant has not proved total disability pursuant to Section 718.204(b)(2)(iii).

Among the physicians who either examined Claimant or reviewed pertinent medical evidence, Drs. Kiser, Ford, Brown, Ladley, Winegar, Rosser, Scott, and Fino provided no opinion relating to the issue of total disability. Dr. Paranthaman opined that the miner is totally disabled from a pulmonary perspective due to coal mine employment. Dr. Branscomb found no impairment related to coal mine employment, but found a moderate to severe pulmonary impairment which he thought would render the miner totally disabled if he did not get treatment. Dr. Kleinerman found a moderate to severe pulmonary impairment due to smoking but not coal mine employment. He did not opine as to whether that impairment rendered the miner totally disabled. Dr. Castle opined that the miner is totally disabled due to chronic obstructive pulmonary impairment attributed to smoking, but not pneumoconiosis. Thus, the physicians who expressed an opinion as to the miner's pulmonary disability, unanimously concluded that in his current state the miner suffers from a totally disabling respiratory impairment. These opinions are supported by the underlying objective medical evidence. They are well documented and reasoned. Accordingly, total disability is also established by the physicians' opinions of record under Section 718.204(b)(2)(iv).

Section 718.204(c)(1) provides that a miner will be considered totally disabled due to pneumoconiosis if the disease is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is considered a "substantially contributing cause" of the disability if it either has a material adverse effect on the miner's respiratory or pulmonary condition, or it materially worsens a totally disabling respiratory or pulmonary impairment caused by a disease unrelated to coal mine employment. Evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability.

Total disability due to pneumoconiosis must be established through a physician's documented and reasoned medical report. Section 718.204(c)(2).

Only Dr. Paranthaman related the miner's disability in any part to coal dust exposure, but even he opined that the miner's disability is primarily related to his cigarette smoking. Drs. Branscomb, Kleinerman, and Castle found no impairment due to coal mine employment; they opined that cigarette smoking was the cause of the miner's respiratory disability.

Because this tribunal has concluded that The miner does not suffer from coal workers' pneumoconiosis, the opinions of Drs. Branscomb, Kleinerman, and Castle are more persuasive than Dr. Paranthaman's. Their opinions are supported by the x-ray evidence, biopsy evidence, CT scan analyses, improvement of pulmonary function following bronchodilator administration, the miner's extensive smoking history, and his relatively short coal mine employment. The interpretations by Drs. Scott and Wheeler that the x-ray abnormalities are probably either sarcoidosis or tuberculosis support the opinions of Drs. Branscomb, Kleinerman, and Castle. Finally, Dr. Paranthaman relied upon radiological evidence of pneumoconiosis to conclude that the miner's totally disabling respiratory condition was caused by coal mine employment. But since the preponderance of the evidence does not establish that the miner has pneumoconiosis, Dr. Paranthaman's conclusion is not well founded, and his opinion is given little if any weight. Accordingly, this tribunal finds, considering the diverse evidence together, that the Claimant has failed to establish that his totally disabling respiratory impairment is due to pneumoconiosis pursuant to Section 718.204(c).

Entitlement

Claimant has not proved the existence of pneumoconiosis or total disability due to pneumoconiosis. Accordingly, his claim for black lung benefits must be denied.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only if benefits are awarded. Since benefits are not awarded in this case, the Act prohibits the charging of any fee for representation in pursuit of the claim before this tribunal.

ORDER

The claim of Fred D. Dean for black lung benefits under the Act is denied.

EDWARD TERHUNE MILLER
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the **Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.** A copy of this notice must also be served on Donald S. Shire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, G.W., Washington, D.C. 20210.